



Use of Minimum Data Set - Home Care (MDS-HC) Assessment for Determining Level of Care Eligibility

Louisiana Department of Health and Hospitals
Office of Aging and Adult Services



Analyzing and viewing Level of Care CAPs for PW 1, 2, & 6 on MDS-HC

Upon completion of the MDS-HC, the assessor/database entry person will enter the information from the MDS-HC in to OAAS' assessment database. The MDS-HC assessor is responsible for reviewing the MDS-HC Client Assessment Protocols (CAPs) to preliminary determine if the individual meets/does not meet a Level of Care (LOC) Pathway for initial or continued functional/medical eligibility in an OAAS administered Home and Community-Based program. The slides that follow summarize this process and can assist the assessor with this step of the assessment and care planning process.

Analyzing and viewing Level of Care CAPs for PW 1, 2, & 6 on MDS-HC

Level of Care (LOC) Pathway (PW) CAPs for PWs 1- Activities of Daily Living (ADLs) , 2 – Cognitive Performance and/or 6 – Behavior will appear in the lower right side of the screen once the “View CAPs” button is clicked (i.e., MDS-HC assessment data is analyzed). It is important that you make sure all sections have been appropriately completed in order to assure an accurate LOC CAP analysis.

Client Name: Ramiro Lopez

Review is suggested if one or more of the following is present:

Question	Client's Response	Possible Responses	Triggering Responses
Did not trigger			
Visual impairment	D1	0	0-3
Ability to see in adequate light when glasses ...			1-3
Any visual limitation/difficulty	D2	0	0-4
See halos or rings around lights ...			1
Worsening of vision	D3	0	0-4
Worsening of vision in last 90 days ...			1

LOCET - PATHWAY 1. Activities of Daily Living

TRIGGERED

Question	Client's Response	Possible Responses	Triggering Responses
Locomotion	H0	1	0-6, 8
Eating	H0	1	0-6, 8
Transfer	H0	3	0-6, 8
Self Mobility	H0	3	0-6, 8
Toilet Use	H0	3	0-6, 8
Dressing	H0	3	0-6, 8
Personal Hygiene	H0	1	0-6, 8
Bathing	H0	4	0-6, 8
Bladder Continence	H1	3	0-6, 8
Medication Management	H1d	1	0-3, 8
Meal Preparation	H1a	3	0-3, 8
Shopping	H1f	3	0-6, 8
Days out of house within a week	H6a	0	0-3
ADL status change in last 90 days	H8	1	0-1

View CAPs

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Analyzing and viewing Level of Care CAPs for PW 1, 2, & 6 on MDS-HC

Another way to view the Level of Care CAPs is by viewing them in the MDS-HC Assessment Log located on the bottom part of the Client Screen. Scroll all the way to the right side of the screen to bring PW 1, 2, & 6 CAPs in to view. Be sure that you have performed the “View CAPs” function first on that MDS-HC to assure you are viewing the correct CAPs results.

Client Name: Ramiro Lopez

ID	Foreign ID	Last Name	First Name	Opened	Prg	Stn	Region	Agency	DOB
2000634		Lopez	Ramiro	06/20/02	2			Test Case	1/31/1954

MDS-HC Assessment List

Type	Locked	Images	Category	ADL	RUG III	Zone	PW1	PW2	PW6
MDS-HC Manual	No	No	Reduced F	4	11	PA_1	Inc	Inc	Inc
Add New MDS-HC	No	No	Reduced F	4	11	PA_1	Inc	Inc	Inc
View MDS-HC	No	No	Reduced F	4	11	PA_1	Inc	Inc	Inc
Delete MDS-HC	No	No	Reduced F	4	11	PA_1	Inc	Inc	Inc
Print MDS-HC	No	No	Reduced F	4	11	PA_1	Inc	Inc	Inc
Print MDS-HC Section	No	No	Reduced F	4	11	PA_1	Inc	Inc	Inc
Print Blank MDS-HC	No	No	Reduced F	4	11	PA_1	Inc	Inc	Inc

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MDS-HC Section Items to Review if PW 1, 2, or 6 Not Triggered for Possible PW 3, 4, or 5 LOC Criteria

If PW 1, 2, or 6 did not trigger, review these MDS-HC assessment Sections to see if any of the **PW 3 – Physician Involvement, 4 – Treatment and Conditions, or 5 – Skilled Rehab Therapies** criteria are present. **Remember:** PW 3, 4, or 5 must be supported by documentation on a Statement of the Medical Status (SMS) form (OAAS-PF-06-009).

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MDS-HC Item	Short Description	MDS-HC Score
J.1.u.	Pneumonia	1 or 2
N.2.a.	Pressure Sores	3 or 4
P.1.f.	Physical Therapy	≥ 45 min
P.1.g.	Occupational Therapy	≥ 45 min
P.1.h.	Speech Therapy	≥ 45 min
P.2.b.	Respirator	1, 2 or 3
P.2.c.	Other Respiratory Treatments	1, 2 or 3
P.2.g.	Dialysis	1, 2 or 3
P.2.i.	IV infusion – Peripheral	1, 2 or 3
P.2.m.	Tracheostomy care	1, 2 or 3
P.2.o.	Occupational Therapy	1, 2 or 3
P.2.p.	Physical Therapy	1, 2 or 3

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LOC Pathway 3, 4, and 5 Criteria for Approval

Pathway 3: Physician Involvement

Either of the following:

1. One day of MD Visits AND at least four new order changes, both occurring in the last 14 days;
2. At least two days of MD visits AND at least two new order changes, both occurring in the last 14 days.



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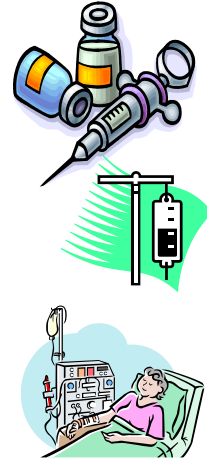
LOC Pathway 3, 4, and 5 Criteria for Approval

Pathway 4: Treatments and Conditions:

Any ONE of the following conditions or treatments:

1. Stage 3-4 Pressure Sores in the last 14 days;
2. IV Feedings in the last 7 days
3. IV Medications in the last 14 days
4. Daily tracheostomy care, daily respirator/ventilator
5. usage, or daily suctioning in the last 14 days
6. Pneumonia in the last 14 days
7. Daily respiratory therapy in the last 14 days
8. Daily insulin injections with 2 or more order changes in the last 14 days (requires both of these criteria listed on SMS)
9. Peritoneal or hemodialysis in the last 14 days

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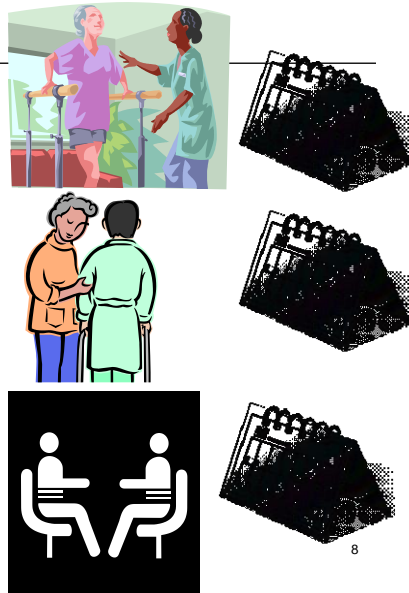
LOC Pathway 3, 4, and 5 Criteria for Approval

Pathway 5: Skilled Rehabilitation Therapies

Either of the following criteria must be met:

1. At least 45 minutes of active **Physical Therapy, Occupational Therapy, and/or Speech Therapy given** in the last 7 days;
2. At least 45 minutes of active **Physical Therapy, Occupational Therapy, and/or Speech Therapy scheduled** for the next 7 days.

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Process for Determining Need for Application of Zero/Eight Protocol

Most individuals who meet Level of Care (LOC) do so on Pathway 1, ADL Performance. The MDS-HC examines the amount of assistance that an individual received from another individual in the performance of Activities of Daily Living (ADLs) during the specified look-back period. **Individuals will trigger PW 1 if they score a “3” or higher (Limited Assistance or Greater) on the late loss ADLs of Bed Mobility, Transfer, Eating, or Toilet Use found in Section H.2 of the MDS-HC. A zero/eight protocol has been established to properly determine LOC using the MDS-HC for individuals who may have significant self-performance difficulties with these late loss ADLs, even though they receive no assistance, and who do not meet LOC on any other Pathway.**

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Process for Determining Need for Application of Zero/Eight Protocol

Step 1. If the individual has scored a “3” – Limited Assistance, “4” – Extensive Assistance, “5” – Maximal Assistance, or a “6” – Total Dependence in Section H. 2 of MDS-HC on any one of the late loss ADLs (i.e., Bed Mobility, Transfer, Eating, or Toilet Use), TeleSys will indicate that the person met LOC on ADL PW1. No further LOC examination is needed and care planning can proceed.

The screenshot shows the TeleSys MDS-HC software interface for Client Name: Ramiro Lopez. The interface is divided into several sections. On the left, there is a sidebar with tabs for 'MDS-HC', 'ADLs', and 'Section H.2'. The 'MDS-HC' tab is selected. The main area displays the 'MDS-HC' form, which includes a table for 'Section H.2' (ADLs). The table has columns for 'ADL', 'Score', and 'Assistance'. The rows are 'Bed Mobility', 'Transfer', 'Eating', and 'Toilet Use'. The scores are 3, 4, 5, and 6 respectively. The assistance levels are 'Limited Assistance' for 'Bed Mobility' and 'Transfer', and 'Maximal Assistance' for 'Eating' and 'Toilet Use'. Red arrows point from the text in Step 1 to these specific items in the form.

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Process for Determining Need for Application of Zero/Eight Protocol

Step 2: If an individual meets LOC on **Pathways 2, 3, 4, 5, or 6** there is no need to apply the zero/eight protocol. Care planning can continue.

(PW 1, 2, & 6 are auto calculated by TeleSys when you click on View CAPs button)

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Client Name: Melvin Brown

LOCET - PATHWAY 2: Cognitive Performance

Question Number	Resident's Response	Possible Responses
D Daily decision making capability	N/A	
D Short term memory	B1a	1 0-1
D Memory exercise questions	N/A	
D Cognitive skills for daily decision making	B2a	4 0-4
D Making self understood	C2	3 0-4
D Change in mental functioning in last 7 days	N/A	

LOCET - PATHWAY 6: Behavior

Question Number	Resident's Response	Possible Responses
D Applicant displays challenging behavior	N/A	
D Wandering	E3a	2 0-2
D Verbally abusive behavior	E3b	2 0-2
D Physically abusive behavior	E3c	0 0-2
D Socially inappropriate / disruptive behavior	E3d	2 0-2
D Delusions	K3f	1 0-1
D Hallucinations	K3g	1 0-1

Process for Determining Need for Application of Zero/Eight Protocol

Step 3: If an individual does **not** meet LOC on **any Pathway**, AND she/he has scored a "0" – "Independent" or an "8" – "Activity Did not Occur" on any late loss ADL - **Bed Mobility, Transfer, Eating or Toilet Use**, then further examination is necessary via application of the Zero/Eight Protocol.

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Client Name: Ramiro Lopez

ADL Decline

ADL status has become worse (i.e., now more impaired in self performance) as compared to status: **ADLs ADL** or since last assessment if less than 30 days

0 No 1 Yes

Primary Modes Of Locomotion

0 No assistive device 3 Scooter (e.g., Amigo)
1 Cane 4 Wheelchair
2 Walker / Crotch
a. Indors b. ACTIVITY DID NOT OCCUR

Application of “0/8” Protocol for Determination of PW 1 Level of Care Using MDS-HC

Step 1: Assessor determines during the face-to-face MDS-HC assessment that the individual indicates that he or she performs an Activity of Daily Living (ADL) independently (score of “0” on MDS-HC – Section H. 2), or individual states the activity did not occur at all during the look-back period (score of “8” on MDS-HC Section H. 2), and the assessor’s observations indicate that the individual may require assistance.



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Application of “0/8” Protocol for Determination of PW 1 Level of Care Using MDS-HC

Step 2: The assessor asks the individual, and/or supports as applicable, the follow-up questions noted below. Examples of situations that may indicate the follow-up questions are required include falls during ADL performance, the assessor’s direct observations during the interview of difficulty in self-performance, or dirty or disheveled appearance.

- **Are you having any difficulty in performing this activity?” If the individual answers “no”, proceed with the assessment of the next activity. If the answer is “yes”, ask the following questions:**
- **“What type of difficulty are you experiencing?”**
- **“Will you accept assistance with this activity?”**



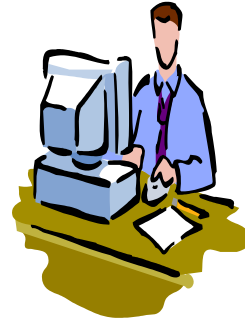
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Application of “0/8” Protocol for Determination of PW 1 Level of Care Using MDS-HC

Step 3: The assessor documents the individual’s responses in the electronic notebook of the MDS-HC. The assessor must document the observation that led to the use of the follow-up questions in the electronic notebook of the MDS-HC. The assessor will record the individual’s description of the difficulty experienced, and add any descriptions of self-performance which the assessor determines to be true depictions of the actual situation, **in the MDS-HC Notebook**. The documentation must include a detailed description of the types of assistance needed. The LOC determination is best supported if the description includes MDS-HC terminology such as “supervision, “guided maneuvering”, “weight-bearing assistance”, required, etc. (See slides 17 & 18 of this guide for an example of how this information should be documented & slides 21-26 for how to Use TeleSys Notebook)

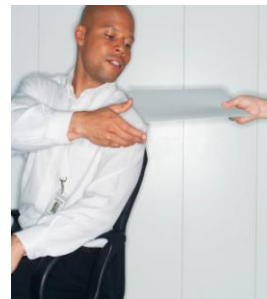
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Application of “0/8” Protocol for Determination of PW 1 Level of Care Using MDS-HC

Important Note: If the assessor is not the person entering MDS-HC assessment in to the TeleSys database, he/she must assure that the Telesys database entry staff person has the necessary documentation to support the application of zero/eight protocol if this process was used to determine PW 1 – ADL LOC. The database staff person will enter this documentation in the MDS-HC TeleSys Notebook at the time of MDS-HC data entry to avoid delays due to a “locked” MDS-HC.



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Application of “0/8” Protocol for Determination of PW 1 Level of Care Using MDS-HC

Mrs. Jones EXAMPLE:

Mrs. Jones states to the assessor that she has had no assistance from another individual with the ADL of eating during the entire 3 day look-back period. The assessor correctly codes Mrs. Jones as a “0” (Independent) on the MDS-HC . The assessor notes that Mrs. Jones’ hands are very contracted, to the point that she cannot straighten her fingers on either hand. The assessor continues assessing Mrs. Jones’ eating patterns to further determine how she is managing with this ADL. She learns from Mrs. Jones’ daughter that Mrs. Jones has recently been hospitalized due to dehydration and weight loss attributed in part to her difficulty with eating ADL, and that Mrs. Jones is only able to consume small portions of food and fluids at one time due to deformity and contractures in her hands and fingers. The assessor also observes that Mrs. Jones cannot properly hold a glass of water, and that most of the fluid is not making it in to her mouth. **Based on this information, the assessor determines that Mrs. Jones’ self-performance difficulty with late loss ADL of eating is at the level of “limited assistance” per MDS-HC coding definition (i.e., Mrs. Jones requires at least guided maneuvering level of assistance with late loss ADL of eating)**

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Application of “0/8” Protocol for Determination of PW 1 Level of Care Using MDS-HC

Mrs. Jones EXAMPLE (continued)

The assessor records the following note in the MDS-HC electronic Notebook (refer to slides 21-26 of this guide for how to Use MDS-HC Notebook): “Mrs. Jones states no difficulty with eating. The assessor determines otherwise in light of contractures noted to both hands, observed difficulty with consumption of fluids, and daughter’s reports of her mother’s recent weight loss and dehydration attributed to eating difficulties. **At least limited assistance required for late loss ADL of eating.”**

It is important to note that even in the presence of an active caregiver, such as would be the case on re-assessment, the individual may meet LOC on Pathway 1 based on application of zero/eight protocol as described here.

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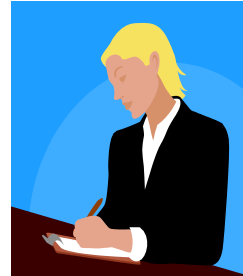
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Application of “0/8” Protocol for Determination of PW 1 Level of Care Using MDS-HC

Step 4:

➤ If the application of Zero/Eight Protocol **does** indicate at least limited level of assistance is required for the late loss ADL(s) examined, make sure appropriate documentation appears in the TeleSys MDS-HC Notebook as described in slides 15-18 of this guide, **and proceed with care planning.**

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Application of “0/8” Protocol for Determination of PW 1 Level of Care Using MDS-HC

Step 5:

- If the application of Zero/Eight Protocol does not indicate at least limited level of assistance is required for the late loss ADL(s) examined, **and the individual meets no other PW, do not continue with Care Planning.**
- **Discuss** with your supervisor
- **Forward** results to OAAS Regional Office for review and determination of LOC met/not met requirements/criteria.

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Using the Notebook

STEP 1

When you view any assessment or client face sheet, you will notice that there is a Notebook section in the right side section buttons. This is a valuable tool that allows you to enter notes on any individual answer box in the assessment, or on any section of the assessment, or the entire assessment.

Client Name: Mark Elton

MINIMUM DATA SET - HOME CARE (MDS-HC)
Unless otherwise noted, score for last 3 days
Examples of exceptions include MDS-1 Continence / Services / Treatments where status scored over last 7 days.

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1. Name of Client: Elton Mark
a. (Last/Family Name) b. (First Name) c. (Middle Name)

2. Case Record No.

3. Government Pension And Health Insurance Numbers
a. Pension (Social Security) Number
b. Health insurance number (if other comparable insurance number)

SECTION BB. PERSONAL ITEMS (Complete at Intake Only)

1. Gender: 1. Male 2. Female

2. Birthdate: Month Day Year

3. Race / Ethnicity: 0. No 1. Yes (Answer All)
a. American Indian/Alaskan Native
b. Asian
c. Black / African Amer
d. Native Hawaiian or other Pacific Islander
e. White
f. Hispanic or Latino

4. Marital Status: 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other

5. Language: Primary Language

Right-hand sidebar buttons: All NameID, BB. Personal, CC. Referral, A. Assess Info, B. Cognitive, C. Communication, D. Vision, E. Mood/Behavior, F. Social, G. Support, H. Physical, I. Continence, J. Disease, K. Health, L. Nutrition, M. Dental, N. Skin, O. Environment, P. Service, Q. Medications, R. Signature, S. Notebook.

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Using the Notebook

STEP 1 (continued)

You may invoke the Notebook at any time by depressing the F5 key on your computer key board, or by clicking on the Notebook section button.

Client Name: Mark Elton

MINIMUM DATA SET - HOME CARE (MDS-HC)
Unless otherwise noted, score for last 3 days
Examples of exceptions include MDS-1 Continence / Services / Treatments where status scored over last 7 days.

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1. Name of Client: Elton Mark
a. (Last/Family Name) b. (First Name) c. (Middle Name)

2. Case Record No.

3. Government Pension And Health Insurance Numbers
a. Pension (Social Security) Number
b. Health insurance number (if other comparable insurance number)

SECTION BB. PERSONAL ITEMS (Complete at Intake Only)

1. Gender: 1. Male 2. Female

2. Birthdate: Month Day Year

3. Race / Ethnicity: 0. No 1. Yes (Answer All)
a. American Indian/Alaskan Native
b. Asian
c. Black / African Amer
d. Native Hawaiian or other Pacific Islander
e. White
f. Hispanic or Latino

4. Marital Status: 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other

5. Language: Primary Language

Right-hand sidebar buttons: All NameID, BB. Personal, CC. Referral, A. Assess Info, B. Cognitive, C. Communication, D. Vision, E. Mood/Behavior, F. Social, G. Support, H. Physical, I. Continence, J. Disease, K. Health, L. Nutrition, M. Dental, N. Skin, O. Environment, P. Service, Q. Medications, R. Signature, S. Notebook.

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Using the Notebook

STEP 2

When you click on the Notebook section button, the notebook section will appear. You cannot type directly into the Notebook section within the form. The notebook display box will display the first few lines of the notebook just to let you know that there is something in the notebook, or you can view the completion graphic next to the Notebook section button.

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The screenshot shows the 'TeleSys Assessment Tools Suite' interface. The client name is 'Mark Etron'. The main section is 'SECTION R. ASSESSOR INFORMATION'. Under '1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:', there is a list of signatures. The 'Signature of Assessment coordinator' is 'Mary Wilson'. The 'Title of Assessment Coordinator' is 'Coordinator'. The 'Date Assessment Coordinator signed as complete' is '01-01-2001'. There is a table for 'Other Signatures' with columns for 'Signature', 'Title', 'Section', and 'Date'. The 'Notebook' section is highlighted with a red box, and a red arrow points to it from the text box on the left. The 'Notebook' section is titled 'NOTEBOOK - General Notes on Assessment' and contains a large blue area for notes.

Using the Notebook

STEP 2 (continued)

If the section button is full, then there is something in the notebook. In order to get to the actual Notebook input screen, either double left click anywhere within the Notebook display box or depress the Enter key if the Notebook display box has the focus.

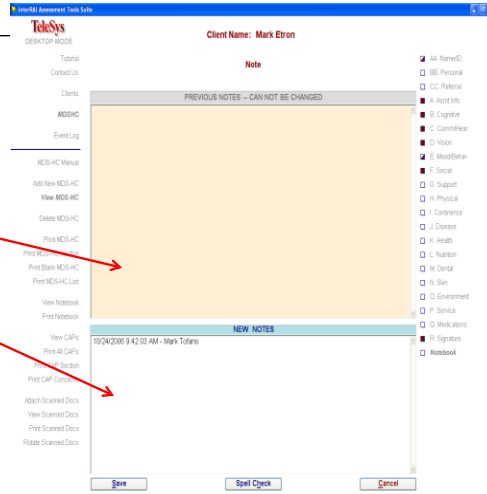
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This screenshot is identical to the one above, showing the 'TeleSys Assessment Tools Suite' interface with the 'Notebook' section highlighted. A red arrow points from the text box on the left to the 'Notebook' section button. The 'Notebook' section is titled 'NOTEBOOK - General Notes on Assessment' and contains a large blue area for notes.

Using the Notebook

STEP 3

The Notebook entry screen will become visible. It is segmented into two parts. The top section is the viewing window and allows you to see all past notes. The lower section is the current input area. You can type into this area and spell check it.



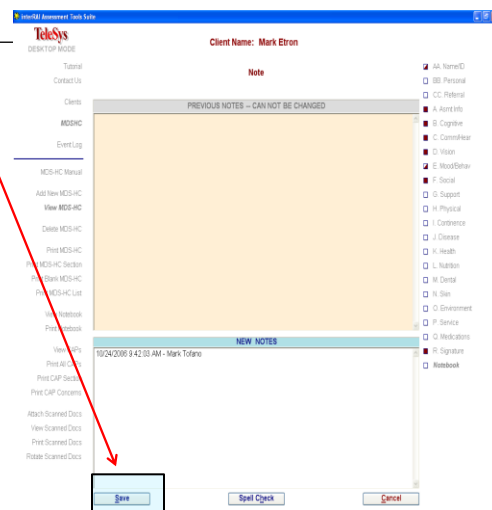
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Using the Notebook

STEP 3 (continued)

Once you have completed your notes, click on the "Save" key to permanently save the text. Once the text has been saved, it cannot be changed. In order to make a correction to the notes, you must actually make another note entry referencing the past error and showing the correction. This technique provides a complete audit trail of notes.



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